Office Use Only

Chart #_____

Health Alerts Yes No

PEDIATRIC DENTISTRY
Of North Texas

PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: _____ Nickname: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ SS#:_____-_____-_____ Age: _____ Sex: Male Female (Circle)

Mother/Legal Guardian: _____ Relation to Patient: _____

Employer: _____ Work #:_____ Cell: _____

Email: _____ Date of Birth: _____ SS#:_____-_____-_____

Father/Legal Guardian: _____ Relation to Patient: _____

Employer: _____ Work #:_____ Cell: _____

Email: _____ Date of Birth: _____ SS#:_____-_____-_____

Person responsible for the account: _____

What other children in your family have we seen? _____

Who referred you to our office? _____

MEDICAL HISTORY

Child's Physician/Pediatrician: _____ Phone: _____

☐ Yes ☐ No Is your child in good health? Date of last physical exam _____

☐ Yes ☐ No Has your child ever had a health problem? _____

☐ Yes ☐ No Is your child allergic to anything? If yes, what? _____

☐ Yes ☐ No Are your child's immunizations/vaccines up to date? If not, please explain: _____

☐ Yes ☐ No Has your child had any surgeries/hospitalizations? If yes, explain _____

☐ Yes ☐ No Is your child currently taking any medications? Please give medications, dose, and reason: _____

_____

Please check if your child has been treated for any of the following:

☐ AIDS	☐ ADHD/ADD	☐ Anemia	☐ Asthma/breathing	☐ Autism
☐ Blood dyscrasias	☐ Cancer/Tumors	☐ Cerebral Palsy	☐ Cleft lip/palate	
☐ Congenital birth defects	☐ Diabetes	☐ Endocrine/growth	☐ Eyesight	☐ Food Allergies
☐ Frequent Infections	☐ Headaches	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ Kidney Disease	☐ Latex Allergy	☐ Liver/GI Disease	☐ Mental delays	☐ Personality/social
☐ Pregnant	☐ Rheumatic fever	☐ Seasonal Allergies	☐ Seizures	☐ Shunt
☐ Sickle Cell Disease	☐ Snoring	☐ Speech/hearing	☐ Spina bifida	☐ Syndrome _____
☐ Tonsil/adenoid	☐ Tuberculous	☐ Other _____		

Has any member of your child's family had any of the above? If yes, please explain _____

_____

DENTAL HISTORY

What is the reason for your child's dental visit?

_____

_____

Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____ ☐ Yes ☐ No
Name of previous dentist _____ Phone _____
Has your child had an unfavorable dental experience? ☐ Yes ☐ No
Has your child had a local anesthetic? ☐ Yes ☐ No
Has your child been sedated for dental treatment? ☐ Yes ☐ No
Have your child's teeth ever been injured? ☐ Yes ☐ No
Has your child had treatment for dental trauma? ☐ Yes ☐ No
Does your child suck a finger, thumb or pacifier or have any other oral habits? ☐ Yes ☐ No
Does your child go to bed with a bottle or sippy cup? ☐ Yes ☐ No
Any family history of tooth/gum problems or missing/extra teeth? Please explain_____☐ Yes ☐ No

_____

Please check if you are concerned that your child has any of the following:

☐ Cavities ☐ Toothache ☐ Sensitive Teeth ☐ Mouth Breathing ☐ Trauma ☐ Gum Infection
☐ Color of teeth ☐ Orthodontics ☐ Jaw Sounds ☐ Grinding of Teeth
☐ Other _____

Comments: _____

FLUORIDE HISTORY

Does your child drink tap water? ☐ Yes ☐ No
Does your child use fluoride toothpaste? ☐ Yes ☐ No
Do you give your child any other forms of fluoride? If yes, what? _____ ☐ Yes ☐ No

LEGAL CONSENT FORM

I give my permission for the following individuals to bring my child to the dentist

1) Name _____ Relationship_____ Phone _____
2) Name _____ Relationship_____ Phone _____
3) Name _____ Relationship_____ Phone _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

CONSENT FOR DENTAL TREATMENT

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. The information listed on both sides of this form is complete and accurate. I give consent for Dr. Robert E Morgan, associate dentists and dental staff to perform a dental exam, dental prophylaxis, fluoride treatment, and take x-rays on my child. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational, or research purposes.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform *Pediatric Dentistry of North Texas* of any changes in my child's medical status.

Parent/Legal Guardian's signature: _____ Date: _____

Doctor's Notes: _____

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